		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0028076

Facility Name: WATERFRONT TERRACE

Address: 7750 S. SHORE DR. (Number) CHICAGO (City) 60645 (Zip Code)

County: COOK

Telephone Number: (847) 679 - 8219 **Fax #** (847) 679 - 7377

IDPA ID Number: 36-3230699

Date of Initial License for Current Owners: 04/01/83

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MARSHALL MAUER
(Title) TREASURER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	42	Skilled (SNF)	42	15,330	1
2		Skilled Pediatric (SNF/PED)			2
3	76	Intermediate (ICF)	76	27,740	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	118	TOTALS	118	43,070	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			2,123	2,123	8
9	SNF/PED					9
10	ICF	34,712	1,887	1,128	37,727	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	34,712	1,887	3,251	39,850	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.52%

D. How many bed-hold days during this year were paid by Public Aid?
1,008 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 4/1/83

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/01/83 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 16 and days of care provided 2,123

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	172,677	21,013	7,818	201,508		201,508		201,508			1
2	Food Purchase		172,724		172,724	(26,499)	146,225	(1,906)	144,319			2
3	Housekeeping	66,499	33,433		99,932		99,932		99,932			3
4	Laundry	50,964	6,050	9,500	66,514		66,514		66,514			4
5	Heat and Other Utilities			53,505	53,505		53,505	872	54,377			5
6	Maintenance	72,334	20,248	10,462	103,044		103,044	9,582	112,626			6
7	Other (specify):*			15,040	15,040		15,040	580	15,620			7
8	**TOTAL General Services**	362,474	253,468	96,325	712,267	(26,499)	685,768	9,128	694,896			8
	B. Health Care and Programs											
9	Medical Director			2,400	2,400		2,400		2,400			9
10	Nursing and Medical Records	1,227,143	80,904	8,646	1,316,693		1,316,693	(3,698)	1,312,995			10
10a	Therapy		352	10,915	11,267		11,267	(158)	11,109			10a
11	Activities	113,150	9,039	2,948	125,137		125,137		125,137			11
12	Social Services			3,928	3,928		3,928		3,928			12
13	Nurse Aide Training											13
14	Program Transportation			960	960		960		960			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,340,293	90,295	29,797	1,460,385		1,460,385	(3,856)	1,456,529			16
	C. General Administration											
17	Administrative	85,658		120,000	205,658		205,658	52,635	258,293			17
18	Directors Fees											18
19	Professional Services			62,495	62,495		62,495	4,751	67,246			19
20	Dues, Fees, Subscriptions & Promotions			61,982	61,982		61,982	(28,714)	33,268			20
21	Clerical & General Office Expenses	119,077	21,969	201,824	342,870		342,870	(208,143)	134,727			21
22	Employee Benefits & Payroll Taxes			464,352	464,352	26,499	490,851		490,851			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,410	2,410		2,410	232	2,642			24
25	Other Admin. Staff Transportation			7,183	7,183		7,183		7,183			25
26	Insurance-Prop.Liab.Malpractice			142,005	142,005		142,005	2,871	144,876			26
27	Other (specify):*							24,545	24,545			27
28	**TOTAL General Administration**	204,735	21,969	1,062,251	1,288,955	26,499	1,315,454	(151,823)	1,163,631			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,907,502	365,732	1,188,373	3,461,607		3,461,607	(146,551)	3,315,056			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number WATERFRONT TERRACE #0028076 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			91,269	91,269		91,269	29,202	120,471			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			24,205	24,205		24,205	196,376	220,581			32
33	Real Estate Taxes			82,252	82,252		82,252	2,536	84,788			33
34	Rent-Facility & Grounds			461,201	461,201		461,201	(461,201)				34
35	Rent-Equipment & Vehicles			10,795	10,795		10,795	7,420	18,215			35
36	Other (specify):*											36
37	**TOTAL Ownership**			669,722	669,722		669,722	(225,667)	444,055			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		43,125	153,811	196,936		196,936	(3,952)	192,984			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			64,605	64,605		64,605		64,605			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		43,125	218,416	261,541		261,541	(3,952)	257,589			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,907,502	408,857	2,076,511	4,392,870		4,392,870	(376,170)	4,016,700			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	18,842	30		9
10	Interest and Other Investment Income	(1,030)	32		10
11	Discounts, Allowances, Rebates & Refunds	(974)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(932)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees		20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions	(6,860)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(291)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(22,446)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(78,388)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (92,079)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(284,091)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (284,091)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (376,170)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

WATERFRONT TERRACE

ID# 0028076

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 917	6	1
2	MARKETING SALARY	(79,305)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(78,388)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WATERFRONT TERRACE **#** 0028076 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,906)	0	0	0	0	0	0	0	0	0	0	(1,906)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	872	0	0	0	0	0	0	0	0	872	5
6	Maintenance	917	0	2,673	5,992	0	0	0	0	0	0	0	9,582	6
7	Other (specify):*	0	0	70	0	510	0	0	0	0	0	0	580	7
8	**TOTAL General Services**	(989)	0	3,615	5,992	510	0	0	0	0	0	0	9,128	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	(3,698)	0	0	0	0	0	(3,698)	10
10a	Therapy	0	0	0	0	0	(158)	0	0	0	0	0	(158)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	(3,856)	0	0	0	0	0	(3,856)	16
	C. General Administration													
17	Administrative	0	(120,000)	0	172,635	0	0	0	0	0	0	0	52,635	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(291)	3,270	1,772	0	0	0	0	0	0	0	0	4,751	19
20	Fees, Subscriptions & Promotions	(29,306)	0	592	0	0	0	0	0	0	0	0	(28,714)	20
21	Clerical & General Office Expenses	(79,305)	(169,000)	34,765	5,397	0	0	0	0	0	0	0	(208,143)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	232	0	0	0	0	0	0	0	0	232	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,871	0	0	0	0	0	0	0	0	2,871	26
27	Other (specify):*	0	0	5,975	0	18,570	0	0	0	0	0	0	24,545	27
28	**TOTAL General Administration**	(108,902)	(285,730)	46,207	178,032	18,570	0	0	0	0	0	0	(151,823)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(109,891)	(285,730)	49,822	184,024	19,080	(3,856)	0	0	0	0	0	(146,551)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number WATERFRONT TERRACE **#** 0028076 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	18,842	6,425	3,935	0	0	0	0	0	0	0	0	29,202	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,030)	193,944	3,462	0	0	0	0	0	0	0	0	196,376	32
33	Real Estate Taxes	0	0	2,536	0	0	0	0	0	0	0	0	2,536	33
34	Rent-Facility & Grounds	0	(461,201)	0	0	0	0	0	0	0	0	0	(461,201)	34
35	Rent-Equipment & Vehicles	0	0	7,420	0	0	0	0	0	0	0	0	7,420	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	17,812	(260,832)	17,353	0	0	0	0	0	0	0	0	(225,667)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	(3,952)	0	0	0	0	0	(3,952)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	(3,952)	0	0	0	0	0	(3,952)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(92,079)	(546,562)	67,175	184,024	19,080	(7,808)	0	0	0	0	0	(376,170)	45

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		SCHEDULE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	BOOKKEEPING FEES	$ 169,000	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$	$ (169,000)	1
2	V	17	MANAGEMENT FEES	120,000	DYNAMIC HEALTHCARE CONSULTANTS			(120,000)	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V	34	RENT	461,201	WATERFRONT TERRACE ASSOCIATES	100.00%		(461,201)	9
10	V	30	DEPRECIATION		WATERFRONT TERRACE ASSOCIATES		6,425	6,425	10
11	V	19	ACCOUNTING & LEGAL		WATERFRONT TERRACE ASSOCIATES		3,270	3,270	11
12	V	32	INTEREST		WATERFRONT TERRACE ASSOCIATES		193,944	193,944	12
13	V								13
14	Total			$ 750,201			$ 203,639	$ * (546,562)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 872	$ 872	15
16	V	6	REPAIRS & MAINT		" " "	100.00%	2,673	2,673	16
17	V	7	EMP.BEN.-GEN.SERVICES		" " "	100.00%	70	70	17
18	V	19	PROFESSIONAL FEES		" " "	100.00%	1,772	1,772	18
19	V	20	DUES & SUBSCRIPTION		" " "	100.00%	592	592	19
20	V	21	CLERICAL & GENERAL		" " "	100.00%	34,765	34,765	20
21	V	24	SEMINARS & TRAVEL		" " "	100.00%	232	232	21
22	V	26	INSURANCE		" " "	100.00%	2,871	2,871	22
23	V	27	EMP.BEN. - GEN.ADMIN		" " "	100.00%	5,975	5,975	23
24	V	30	DEPRECIATION		" " "	100.00%	3,935	3,935	24
25	V	32	INTEREST		" " "	100.00%	3,462	3,462	25
26	V	33	REAL ESTATE TAXES		" " "	100.00%	2,536	2,536	26
27	V	35	EQUIPMENT RENTAL		" " "	100.00%	7,420	7,420	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 67,175	$ * 67,175	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	MAINT. CMP.-D.NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 5,992	$ 5,992	15
16	V	10	NURSING CMP - SUE G.		" " "	100.00%			16
17	V	17	ADMIN CMP.-M. MAUER		" " "	100.00%	33,496	33,496	17
18	V	17	ADMIN CMP.-M. AARON		" " "	100.00%	49,531	49,531	18
19	V	17	ADMIN CMP.- F. AARON		" " "	100.00%	27,923	27,923	19
20	V	17	ADMIN CMP.- S. GOLDSTEIN		" " "	100.00%			20
21	V	17	ADMIN CMP.- S. KOPLIN		" " "	100.00%	9,521	9,521	21
22	V	17	ADMIN CMP.- D. MAGAFAS		" " "	100.00%	11,192	11,192	22
23	V	17	ADMIN CMP.- E. CASSON		" " "	100.00%			23
24	V	17	ADMIN CMP.- S. BOGEN		" " "	100.00%			24
25	V	17	ADMIN CMP.- S. LEVY		" " "	100.00%	12,974	12,974	25
26	V	17	ADMIN CMP.- H. ALTER		" " "	100.00%	12,000	12,000	26
27	V	17	ADMIN. CMP.-NON-OWNER		" " "	100.00%	15,998	15,998	27
28	V	21	CLERICAL CMP.- S. AARON		" " "	100.00%	5,397	5,397	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 184,024	$ * 184,024	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	7	EMP. BEN.- D. NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 510	$ 510	15
16	V	15	EMP. BEN.- SUE G.		" " "	100.00%			16
17	V	27	EMP. BEN.- M. MAUER		" " "	100.00%	1,456	1,456	17
18	V	27	EMP. BEN.- M. AARON		" " "	100.00%	1,856	1,856	18
19	V	27	EMP. BEN.- F. AARON		" " "	100.00%	4,125	4,125	19
20	V	27	EMP. BEN.- S. GOLDSTEIN		" " "	100.00%			20
21	V	27	EMP. BEN.- S. KOPLIN		" " "	100.00%	3,014	3,014	21
22	V	27	EMP. BEN.-D. MAGAFAS		" " "	100.00%	1,552	1,552	22
23	V	27	EMP. BEN.- E. CASSON		" " "	100.00%			23
24	V	27	EMP. BEN.- S. BOGEN		" " "	100.00%			24
25	V	27	EMP. BEN.- S. LEVY		" " "	100.00%	1,873	1,873	25
26	V	27	EMP. BEN.- H. ALTER		" " "	100.00%	1,296	1,296	26
27	V	27	EMP. BEN.- NON-OWNER		" " "	100.00%	2,385	2,385	27
28	V	27	EMP. BEN.- S. AARON		" " "	100.00%	1,013	1,013	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 19,080	$ * 19,080	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10a	THERAPY	$ 8,802	DYNAMIC REHAB CONSULTANTS LLC	100.00%	$ 8,644	$ (158)	15
16	V	19	PROFESSIONAL FEES		DYNAMIC REHAB CONSULTANTS LLC	100.00%			16
17	V	22	EMPLOYEE BENEFITS		DYNAMIC REHAB CONSULTANTS LLC	100.00%			17
18	V	39	ANCILLARY SERVICES	139,813	DYNAMIC REHAB CONSULTANTS LLC	100.00%	137,302	(2,511)	18
19	V								19
20	V								20
21	V	10	MEDICAL SUPPLIES	25,649	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	21,951	(3,698)	21
22	V	39	ANCILLARY EXPENSE	9,995	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	8,554	(1,441)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 184,259			$ 176,451	$ * (7,808)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MARSHALL MAUER		ADMINISTRATION			SCHEDULE ATTACHED		SALARY	$ 33,496	17-7	1
2	MAURICE AARON		ADMINISTRATION					SALARY	49,531	17-7	2
3	FRED AARON		ADMINISTRATION					SALARY	27,923	17-7	3
4											4
5	SHARON AARON		CLERICAL					SALARY	5,397	21-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 116,347		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	TOTAL PATIENT DAYS	441,841	13	$ 9,671	$	39,850	$ 872	1
2	6	REPAIR & MAINT	" "	441,841	13	29,639	3,380	39,850	2,673	2
3	7	EMP. BEN.- GEN. SVC.	" "	441,841	13	778		39,850	70	3
4	19	PROFESSIONAL FEES	" "	441,841	13	19,651		39,850	1,772	4
5	20	DUES & SUBSCRIPTIONS	" "	441,841	13	6,566		39,850	592	5
6	21	CLERICAL & GENERAL	" "	441,841	13	385,463	300,175	39,850	34,765	6
7	24	SEMINARS & TRAVEL	" "	441,841	13	2,576		39,850	232	7
8	26	INSURANCE	" "	441,841	13	31,835		39,850	2,871	8
9	27	EMP. BEN.- GEN. ADM.	" "	441,841	13	66,254		39,850	5,975	9
10	30	DEPRECIATION	" "	441,841	13	43,634		39,850	3,935	10
11	32	INTEREST	" "	441,841	13	38,384		39,850	3,462	11
12	33	REAL ESTATE TAXES	" "	441,841	13	28,121		39,850	2,536	12
13	35	EQUIPMENT RENTAL	" "	441,841	13	82,269		39,850	7,420	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 744,841	$ 303,555		$ 67,175	25

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINT.CMP.- D. NEHMER	WGHTD. AVG. HOURS	40	10	$ 59,032	$ 59,032	4	$ 5,992	1
2	10	NURSING- SUE G.	" "	40	1	32,744	32,744			2
3	17	ADMIN.CMP.- M. MAUER	" "	40	12	363,103	363,103	4	33,496	3
4	17	ADMIN.CMP.- M. AARON	" "	40	10	487,988	487,988	4	49,531	4
5	17	ADMIN.CMP.- F. AARON	" "	45	6	193,312	193,312	7	27,923	5
6	17	ADMIN.CMP.- S. GOLDSTEIN	" "	37	2	153,497	153,497			6
7	17	ADMIN.CMP.- S. KOPLIN	" "	40	8	71,542	71,542	5	9,521	7
8	17	ADMIN.CMP.- D. MAGAFAS	" "	45	9	87,437	87,437	6	11,192	8
9	17	ADMIN.CMP.- E. CASSON	" "	38	1	31,246	31,246			9
10	17	ADMIN.CMP.- S. BOGEN	" "	45	2	54,060	54,060			10
11	17	ADMIN.CMP.- S. LEVY	" "	45	12	140,632	140,632	4	12,974	11
12	17	ADMIN.CMP.- H. ALTER	" "	40	1	12,000	12,000	40	12,000	12
13	17	ADMIN.CMP.- NON-OWNER	" "	45	12	157,563	157,563	5	15,998	13
14	21	CLERICAL CMP.- S. AARON	" "	40	12	58,502	58,502	4	5,397	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,902,658	$ 1,902,658		$ 184,024	25

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	7	EMP. BEN. - D. NEHMER	WGHTD AVG. HOURS	40	10	$ 5,020	$	4	$ 510	1
2	15	EMP. BEN. - SUE G.	" " "	40	1	3,128				2
3	27	EMP. BEN. - M. MAUER	" " "	40	12	15,782		4	1,456	3
4	27	EMP. BEN. - M. AARON	" " "	40	10	18,288		4	1,856	4
5	27	EMP. BEN. - F. AARON	" " "	45	6	28,556		7	4,125	5
6	27	EMP. BEN. - S. GOLDSTEIN	" " "	37	2	25,672				6
7	27	EMP. BEN. - S. KOPLIN	" " "	40	8	22,644		5	3,014	7
8	27	EMP. BEN. - D. MAGAFAS	" " "	45	9	12,125		6	1,552	8
9	27	EMP. BEN. - E. CASSON	" " "	38	1	3,418				9
10	27	EMP. BEN. - S. BOGEN	" " "	45	2	5,010				10
11	27	EMP. BEN. - S. LEVY	" " "	45	12	20,299		4	1,873	11
12	27	EMP. BEN. - H. ALTER	" " "	40	1	1,296		40	1,296	12
13	27	EMP. BEN. - NON-OWNER	" " "	45	12	23,491		5	2,385	13
14	27	EMP. BEN. - S. AARON	" " "	40	12	10,982		4	1,013	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 195,711	$		$ 19,080	25

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W. MAIN. ST.
City / State / Zip Code: SKOKOIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		DYNAMIC REHAB CONSULTANTS				$	$		$	1
2	10a	THERAPY	DIRECT ALLOCATION						8,644	2
3	19	PROFESSIONAL FEES	" "							3
4	22	EMPLOYEES BENEFITS	" "							4
5	39	ANCILLARY SERVICES	" "						137,302	5
6										6
7										7
8		LINCOLN MEDICAL SUPPLIES	DIRECT ALLOCATION							8
9	10	MEDICAL SUPPLIES	" "						21,951	9
10	39	ANCILLARY EXPENSES	" "						8,554	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 176,451	25

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	SUCCESS BANK		X	MORTGAGE	$43,437.00	10/99	$ 3,050,000	$ 2,356,672	11/09	7.7500	$ 193,944	1
2												2
3												3
4												4
5	RELATED PARTY	X									3,462	5
	Working Capital											
6	SUCCESS BANK		X	WORKING CAPITAL				159,143			20,841	6
7	BANK FINANCIAL		X	VAN				11,377			119	7
8	UPAC		X	INSURANCE FINANCING							3,245	8
9	TOTAL Facility Related				$43,437.00		$ 3,050,000	$ 2,527,192			$ 221,611	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,050,000	$ 2,527,192			$ 221,611	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 80,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 80,252	2
3. Under or (over) accrual (line 2 minus line 1).		$ 252	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 82,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 82,252	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	81,723	8
	1998	83,174	9
	1999	82,615	10
	2000	78,218	11
	2001	80,252	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2001 TAX BILL.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WATERFRONT TERRACE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0028076

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2001

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	21-30-412-045-0000	NURSING HOME	$ 79,437.00	$ 79,437.00
2.	21-30-412-038-0000	NURSING HOME	$ 815.00	$ 815.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 80,252.00	$ 80,252.00

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services' ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,824 B. General Construction Type: Exterior BRICK Frame STEEL & CONCRET Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	37,824	1983	$ 100,000	1
2					2
3	TOTALS	37,824		$ 100,000	3

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1983		$ 1,508,000	$	35	$ 43,086	$ 43,086	$ 850,949	4
5											5
6											6
7											7
8					40,009	1,026		1,143	117	10,669	8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENT			1983	21,787		10			21,787	9
10	LEASEHOLD IMPROVEMENT			1985	950		15			950	10
11	LEASEHOLD IMPROVEMENT			1986	3,800	160	10		(160)	3,800	11
12	LEASEHOLD IMPROVEMENT			1986	1,005	42	15		(42)	1,029	12
13	LEASEHOLD IMPROVEMENT			1990	13,634	433	10	685	252	13,634	13
14	LEASEHOLD IMPROVEMENT			1990	20,776	660	15	1,385	725	17,313	14
15	LEASEHOLD IMPROVEMENT			1991	7,956	253	10		(253)	8,388	15
16	LEASEHOLD IMPROVEMENT			1991	1,491	47	15	99	52	1,109	16
17	LEASEHOLD IMPROVEMENT			1992	18,033	572	10	904	332	18,033	17
18	LEASEHOLD IMPROVEMENT			1992	1,097	35	15	73	38	767	18
19	LEASEHOLD IMPROVEMENT			1993	7,742	246	31.5	246		2,388	19
20	LEASEHOLD IMPROVEMENT			1993	3,426	88	39	88		832	20
21	LEASEHOLD IMPROVEMENT			1994	25,007	642	39	642		5,430	21
22	ELEVATOR REPAIR			1995	1,500	38	39	38		300	22
23	SPRINKLER REPAIR			1995	4,154	107	39	107		833	23
24	BOILER REPAIR, WATER PUMP, ALARM			1996	6,033	154	39	154		1,034	24
25	FENCING			1996	756	50	15	50		325	25
26	NURSE STATION			1996	5,300	136	39	136		833	26
27	HANDRAILS			1996	3,735	96	39	96		580	27
28	PARKING LOT REPAVING			1997	14,968	998	15	998		5,488	28
29	TUCKPOINTING, ROOF REPAIR			1997	25,814	662	39	662		3,558	29
30	DRAPERY			1997	14,754	378	39	378		2,024	30
31	DOORS & SIGNS			1997	8,428	216	39	216		1,161	31
32	AIR HANDLER REPAIR & PUMPS			1997	17,005	436	39	436		2,344	32
33	REMODELING			1997	59,133	1,517	39	1,517		8,312	33
34	NURSE STATION			1997	5,106	131	39	131		704	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	FLOOR TILES, HANDRAILS, BUMPERGUARDS	1998	$ 44,786	$ 1,148	39	$ 1,148	$	$ 5,108	37
38	RESIDENT ROOM SIGNS, DOORHOLDERS, DOOR MAGNETS	1998	6,419	165	39	165		738	38
39	SPRINKLER WORK, ALARMS, SECURITY DOOR	1998	3,636	93	39	93		419	39
40	CUBICLE CURTAINS, WINDOW TREATMENTS	1998	8,000	205	39	205		914	40
41	BEAUTY SALON STATION	1998	2,042	52	39	52		224	41
42	REMODELING	1998	21,934	562	39	562		2,482	42
43	FENCING, LANDSCAPING	1998	5,089	339	15	339		1,525	43
44	GENERATOR, ELEVATOR REPAIR	1998	3,825	98	39	98		439	44
45	TUCKPOINTING, ROOF WORK	1998	21,000	538	39	538		2,386	45
46	ANTENNA & INSTALLATION	1998	17,323	444	39	444		1,963	46
47	LIGHT FIXTURES, ARTWORK	1998	10,050	259	39	259		1,142	47
48	FIRE ALARM	1999	10,286	264	39	264		976	48
49	BATHROOMS REMODELING	1999	35,657	914	39	914		3,332	49
50	BOILER WORK	1999	7,345	188	39	188		693	50
51	CABLE WORK	1999	433	11	39	11		42	51
52	CARPET	1999	18,828	483	39	483		1,735	52
53	ELEVATOR WORK	1999	2,017	52	39	52		191	53
54	AIR CONDITIONING	1999	7,350	188	39	188		719	54
55	LIGHT AND MIRRORS	1999	9,093	233	39	233		813	55
56	ROOF WORK	1999	2,187	56	39	56		198	56
57	ROOMS IMPROVEMENTS	1999	59,493	1,525	39	1,525		5,107	57
58	WINDOWS	1999	5,513	141	39	141		509	58
59	RELATED PARTY - NURSE CALL SYSTEM	1999	32,456	833	39	833		2,879	59
60	RELATED PARTY - NURSE STATION	1999	19,656	504	39	504		1,743	60
61	RELATED PARTY - DRYWALL, PAINT, FLOORING	1999	176,452	4,524	39	4,524		15,649	61
62	RELATED PARTY - FIRE SYSTEM DAMPERS	1999	22,000	564	39	564		1,952	62
63	NURSE CALL SYSTEM	2000	2,778	103	27.5	103		254	63
64	BATHROOM REMODEL	2000	10,080	367	27.5	367		961	64
65	FIRE ALARM REPAIR	2000	3,170	115	27.5	115		306	65
66	WALLTILE/FLOORING/KICK PLATES/BASEBOARD	2000	10,242	372	27.5	372		971	66
67	DRYWALL & CEILING REPAIR	2000	79,500	2,891	27.5	2,891		7,498	67
68	1ST FLOOR REMODEL	2000	2,698	98	27.5	98		246	68
69	DOOR/DOORBELL INTERCOM/PAGER	2000	2,640	96	27.5	96		242	69
70	TOTAL (lines 4 thru 69)		$ 2,505,377	$ 27,548		$ 71,695	$ 44,147	$ 1,048,930	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,505,377	$ 27,548		$ 71,695	$ 44,147	$ 1,048,930	1
2	EXHAUST FAN	2000	890	32	27.5	32		89	2
3	HOT WATER HEATER	2000	1,100	40	27.5	40		107	3
4	OVERBED LIGHTS	2000	3,093	112	27.5	112		300	4
5	WINDOW TREATMENTS/CUBICLE CURTAINS	2000	11,247	1,967	7	1,967		5,002	5
6	ROOF REPAIRS	2001	7,445	271	27.5	271		481	6
7	LOCKS, DOORS, NURSE STATION MONITOR	2001	6,180	225	27.5	225		377	7
8	OUTLETS, TRANSFERSWITCH	2001	5,686	207	27.5	207		344	8
9	VALVES, BASEMENT REPAIR	2001	6,136	223	27.5	223		375	9
10	LIGHT FIXTURES	2001	2,450	89	27.5	89		147	10
11	AC UNIT	2001	786	29	27.5	29		43	11
12	BOILER/WATER TOWER REPAIR	2002	5,055	138	27.5	138		138	12
13	ELEVATOR REPAIR	2002	6,244	45	27.5	45		45	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,561,689	$ 30,926		$ 75,073	$ 44,147	$ 1,056,378	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 434,426	$ 50,361	$ 39,100	$ (11,261)		$ 311,663	71
72	Current Year Purchases	51,103	17,432	2,555	(14,877)		2,555	72
73	Fully Depreciated Assets	343,950					343,950	73
74	RELATED PARTY	23,761	1,478	2,051	573		14,800	74
75	TOTALS	$ 853,240	$ 69,271	$ 43,706	$ (25,565)		$ 672,968	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	RELATED PARTY			$ 5,077	$ 1,432	$ 1,692	$ 260		$ 3,523	76
77										77
78										78
79										79
80	TOTALS			$ 5,077	$ 1,432	$ 1,692	$ 260		$ 3,523	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,520,006	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 101,629	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 120,471	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 18,842	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,732,869	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number WATERFRONT TERRACE STATE OF ILLINOIS # 0028076 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NA

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 3,756 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMINISTRATIVE	TOYOTA CAMRY	$ 565.00	$ 2,071	17
18		2001 HONDA	414.00	4,968	18
19	PAYROLL DEDUCTION				19
20					20
21	TOTAL		$ 979.00	$ 7,039	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 63,662	$		$ 63,662	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			1,561			1,561	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			84,936			84,936	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				31,224		31,224	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Med.Supplies, Lab.	39-2 & 3					15,553		15,553	13
14	TOTAL			$		$ 150,159	$ 46,777		$ 196,936	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number WATERFRONT TERRACE **#** 0028076 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2002 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	793,279		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	57,499		6
7	Other Prepaid Expenses	1,740		7
8	Accounts Receivable (owners or related parties)	7,716		8
9	Other(specify): RE TAX ESCROW	35,871		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 896,105	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	763,115		15
16	Equipment, at Historical Cost	844,404		16
17	Accumulated Depreciation (book methods)	(806,366)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe DEPOSITS	425		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 801,578	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,697,683	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 345,278	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	170,520		29
30	Accrued Salaries Payable	153,503		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,372		31
32	Accrued Real Estate Taxes(Sch.IX-B)	82,000		32
33	Accrued Interest Payable	680		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 761,353	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 761,353	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 936,330	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,697,683	$	48

***(See instructions.)**

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,026,935	1
2	Restatements (describe):		2
3	ILLINOIS REPLACEMENT TAX	(1,882)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,025,053	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	157,277	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(246,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (88,723)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 936,330	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,494,898	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,494,898	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	53,245	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 53,245	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,030	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,030	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DISCOUNTS	974	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 974	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,550,147	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	712,267	31
32	Health Care	1,460,385	32
33	General Administration	1,288,955	33
	B. Capital Expense		
34	Ownership	669,722	34
	C. Ancillary Expense		
35	Special Cost Centers	196,936	35
36	Provider Participation Fee	64,605	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,392,870	40
41	**Income before Income Taxes (line 30 minus line 40)****	157,277	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 157,277	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,285	2,563	$ 74,702	$ 29.15	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,041	3,196	64,005	20.03	3
4	Licensed Practical Nurses	28,335	31,048	553,212	17.82	4
5	Nurse Aides & Orderlies	59,379	62,738	488,722	7.79	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,884	1,953	23,595	12.08	9
10	Activity Assistants	10,855	11,540	89,555	7.76	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,536	1,774	23,040	12.99	13
14	Head Cook	5,541	6,165	57,370	9.31	14
15	Cook Helpers/Assistants	10,850	11,410	92,267	8.09	15
16	Dishwashers					16
17	Maintenance Workers	4,931	5,152	72,334	14.04	17
18	Housekeepers	9,755	9,892	66,499	6.72	18
19	Laundry	5,952	6,898	50,964	7.39	19
20	Administrator	1,996	2,276	85,658	37.64	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,475	6,951	119,077	17.13	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	951	1,066	9,357	8.78	31
32	Other Health Ca CARE PLAN COC	1,762	1,998	37,145	18.59	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	155,528	166,620	$ 1,907,502 *	$ 11.45	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	250	$ 7,680	1-3	35
36	Medical Director	48	2,400	9-3	36
37	Medical Records Consultant	38	1,218	10-3	37
38	Nurse Consultant	69	2,208	10-3	38
39	Pharmacist Consultant	131	5,220	10-3	39
40	Physical Therapy Consultant	66	3,616	10a-3	40
41	Occupational Therapy Consultant	139	7,065	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	4	234	10a-3	43
44	Activity Consultant	66	2,948	11-3	44
45	Social Service Consultant	74	3,928	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	884	$ 36,517		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
HOWARD ALTER	ADMIN	0	$ 85,658
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 85,658

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 120,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 120,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
HEALTH DATA SYSTEM	DATA PROCESSING	$ 3,719
KRUPNICK, BOKOR	ACCOUNTING	18,588
FROST RUTTENBERG	ACCOUNTING	5,955
OSTROW REISIN	ACCOUNTING	1,242
SACHNOFF & WEAVER	LEGAL	6,072
FINKEL MARTWICK	LEGAL	669
PERSONNEL PLANNERS	UC CONSULTANT	2,025
ECONOCARE	PURCHASING CONSULTANT	2,124
FOX RIVER FOODS	PURCHASING CONSULTANT	2,250
DART CHART SYSTEMS	MEDICARE CONSULTANT	19,560
BRENDA COHEN	COLLECTION FEES	291
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 62,495

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 52,665
Unemployment Compensation Insurance	20,279
FICA Taxes	145,396
Employee Health Insurance	211,503
Employee Meals	26,499
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	29,313
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	0
CHICAGO HEAD TAX	5,196
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 490,851

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	21,210
Health Care Worker Background Check	2,597
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	22,446
TRUST/FRANCHISE/CONTRIB/ETC	6,860
LICENSES & PERMITS	2,039
DUES & SUBSCRIPTIONS	6,630
MGMT CO ALLOCATION	592
TRUST/FRANCHISE/CONTRIB/ETC	(6,860)
Less: Public Relations Expense	(0)
Non-allowable advertising	(22,446)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 33,268

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
RELATED PARTY	232
Seminar Expense	
EDUCATION & SEMINAR	2,410
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,642

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	PAINTING/DECORATIN	1999	$ 5,502	3	$ 917	$ 1,834	$ 1,834	$ 917	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 5,502		$ 917	$ 1,834	$ 1,834	$ 917	$	$	$	$	$

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL ON LONG TERM CARE $1,905.**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **3,877** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **64,605**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **26,499** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: WATERFRONT TERRACE **#0028076** **Report Period Beginning: 01/01/2002** **Ending: 12/31/2002**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	7,680	
	REPAIRS & MAINTENANCE		138	
			0	7,818
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		1,933	
	LINEN REPLACEMENT		7,567	9,500
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		35,013	
	ELECTRICITY		10,556	
	WATER		7,936	
	CABLE TV - LOBBY		0	
			0	53,505
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		651	
	PAINTING & DECORATING		92	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		2,166	
	ELEVATOR MAINTENANCE & REPAIR		4,553	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		3,000	
	FIRE SERVICE		0	
			0	
			0	
			0	10,462
7	**OTHER**			
	SCAVENGER		15,040	
	SECURITY SERVICE		0	15,040
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	2,400	2,400

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,218	
	PHARMACY CONSULTANT	XVIII B 39-2	5,220	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	2,208	
			0	
			0	8,646
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	3,616	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	7,065	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	234	10,915
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,948	
			0	2,948
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	3,928	
			0	3,928
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number WATERFRONT TERRACE **#0028076** **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		960	960
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	120,000	120,000
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	3,719	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	58,485	
	COLLECTION FEES		291	62,495
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	22,446	
	EMPLOYEE WANT ADS	XIX F	21,210	
	CONTRIBUTIONS	VI 20 XIX F	360	
	DUES & SUBSCRIPTIONS	XIX F	6,630	
	LICENSES & PERMITS	XIX F	2,239	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	6,500	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	2,597	61,982
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES		3,725	
	EQUIPMENT REPAIR & MAINTENANCE		9,147	
	OUTSIDE CLERICAL SERVICES		169,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		19,952	
	MESSENGER SERVICE		0	
				201,824

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	145,396	
	UNEMPLOYMENT COMPENSATION	XIX D	20,279	
	WORKERS COMPENSATION INSURANC	XIX D	52,665	
	HOSPITALIZATION INSURANCE	XIX D	211,503	
	EMPLOYEE BENEFITS - OTHER	XIX D	29,313	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	5,196	464,352
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	2,410	
	TRAVEL	XIX G	0	
			0	
			0	2,410
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		7,183	7,183
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		142,005	142,005
27	**OTHER**			
	BAD DEBTS	VI 24	0	
			0	0

GRAND TOTAL COLUMN 3 OTHER 1,188,373

WATERFRONT TERRACE
EMPLOYEE MEAL RECLASSIFICATION
12/31/2002

TOTAL FOOD PURCHASE	172,724
LESS SALES TAX	(932)
NET FOOD	171,792
TOTAL PATIENT CENSUS	39,850
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	119550
ADD # EMPLOYEE MEALS/DAY	60
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	21900

PATIENT MEALS	119550
ADD EMPLOYEE MEALS	21900
TOTAL MEALS/YEAR	141450
NET FOOD	171792
DIVIDE TOTAL MEALS/YEAR	141450
COST PER MEAL	1.21
TIME EMPLOYEE MEALS	21900
EMPLOYEE MEAL RECLASSIFICATION	26499